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EDITORIAL COMMENTARY

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Good news for chronic migraine

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Chronic migraine, with or without analgesic overuse, is a frequent condition. Its prevalence almost reaches 3% in the general population [1]. In addition, it is one of the most frequent reasons for consultation in a general neurological department and accounts for around one-third of visits to headache centres. In spite of this relevant frequency, its treatment has remained almost forgotten. In fact, patients approaching a migraine frequency close to that required for chronic migraine diagnosis (15 or more days per month) have been automatically excluded from conventional trials for migraine prevention. Several reasons explain this unfair exclusion. Difficulties in its conceptual definition since the appearance of the previous IHS Classification, which led to Silberstein and Lipton's transformed migraine criteria [2], were the first of these reasons. Second is the concept that most of these patients in fact suffered from headache secondary to analgesic overuse and that their treatment would just be withdrawal. Finally, and related to the previous idea is the perception that these patients were very difficult to treat and refractory to all preventatives. The paper by Peres et al. [3] appearing in this issue supports those of us who think that chronic migraine patients may specifically improve with preventatives, especially on topiramate, even if they continue overusing symptomatic treatments.

Peres et al. [3] treated 64 chronic migraine patients, both with and without analgesic overuse, with topiramate (median dose 100 mg/day). A reduction in frequency higher than 50% occurred in 66% of these patients after 12 weeks and was not different in overusers *vs*. those who were not overusers. Their results totally concur with those coming from different parts of the world and using similar courses of treatment not only with topiramate [4–8] but also with other neuromodulators, such as valproate [8, 9] or gabapentin [10]. It can be argued, of course, that the methodology of these trials is far from ideal as they are open studies, with the exception of the gabapentin trial, where the advantage for placebo was small. Fortunately the first available placebo-controlled data on the treatment of chronic migraine with topiramate are in line with those coming from its open trials. Silvestrini et al. [11] were the first to show that topiramate at low doses, 50 mg daily, is an effective therapeutic approach to reducing headache frequency in patients with chronic migraine and analgesic overuse. In the recent EHF Congress held in Valencia, Diener et al. [12] reported a significant, and clinically relevant, reduction in

migraine frequency with topiramate *vs*. placebo in patients also suffering from chronic migraine and analgesic overuse. These results could be summarised by saying that chronic migraine is a treatable condition with a preventative such as topiramate, regardless of concomitant overuse. It does not mean that symptomatic treatment withdrawal is not important in the management of these patients. Rational use of acute treatment, trying to limit use to under 2 days per week and avoiding abortive medications with high incidence of rebound – such as combination analgesics, opioids and ergotics – continues to be a milestone in the management of such patients. From data generated with topiramate and from the clinical experience of many of us, however, I would also recommend an early use of preventatives in chronic migraine patients, together with the current withdrawal instructions. Some chronic migraine patients with no response to individual preventatives can also respond to combinations such as a β-blocker plus topiramate (Pascual and Leira, in preparation).

The good news for chronic migraine patients does not seem to stop at topiramate or other neuromodulators. Phase II results have shown some efficacy of botulinum toxin A injections for the treatment of this condition [13]. Finally, Matharu et al. [14] have reported eight chronic migraine patients with marked response with implantation of bilateral suboccipital stimulators. This beneficial response was maintained for a follow-up of 1.5 years. All these still preliminary results should change our mind on treating chronic migraine patients. Their management is not, obviously, easy, but several approaches are now worth trying for these desperate pain sufferers.

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